

PLEASE USE A BLACK
BALL POINT PEN TO
COMPLETE FORM

Employer's Health Insurance Information

Case #: _____

- This form **MUST** be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.

A General Information

Employee Name : _____ SS#: _____

Company Name: _____ EIN: _____

☐ Yes ☐ No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐ Yes ☐ No 2. Is the employee eligible to enroll in any insurance plan offered?

If no, please explain: _____

If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

☐ Yes ☐ No 3. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of persons enrolled: _____

☐ Yes ☐ No 4. Has this employee or any family member dropped/changed coverage in the last six months?

If yes, name(s): _____

If yes, when did coverage end/change? (mm/dd/yy) _____

B Least Expensive Plan

Questions below refer to the **least expensive** plan offered at your company.

☐ Yes ☐ No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) _____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$ _____	\$ _____
Employee + spouse	\$ _____	_____
Employee + child	\$ _____	_____
Family	\$ _____	_____

5. Please list the yearly health plan deductible (not the "out of pocket" cost or hospital deductible).

Individual amount \$ _____ Family amount \$ _____

☐ Yes ☐ No 6. Does the plan pay for any services (doctor, pharmacy, etc.) before the employee has met the deductible listed above?

(continued)



Employee Name: _____ SS#: _____ Case #: _____

C Employee's Health Plan Choice

Questions below refer to the plan the employee has selected. Questions 2-8 refer to "in-network" benefits.

1. Insurance company and plan name: _____
- ☐ Yes ☐ No 2. Is the deductible \$2,500 or less per individual?
- ☐ Yes ☐ No 3. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- ☐ Yes ☐ No 4. Is the lifetime maximum benefit \$1,000,000 or more?
5. What benefits are covered under this plan? (Check all that apply.)
- ☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx
- ☐ Well-child exams ☐ Child immunizations
6. Complete this chart only if it is different from the chart on the front page (section B). **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

- ☐ Yes ☐ No 7. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____
- ☐ Yes ☐ No 8. Does the plan cover abortion services?
- If yes, under what circumstances:
- ☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
- ☐ Other, please describe: _____

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9500
Toll-free Fax: 1-877-313-4717